

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAY 12 1944

State File No.

Registration District No. 366

Primary Registration District No. 6242

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Washington

(b) City or town rural, Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington

(c) City or town rural
(If outside city or town limits, write "RURAL")

(d) Street No. Cannon Miss.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Thomas Michael Boyer

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex M. 5. Color or race W.

6. (a) Single, widowed, married, divorced no

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased April 13 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. min.

9. Birthplace Washington Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business.....

12. Name Thomas William Boyer

13. Birthplace Washington Mo
(City, town, or county) (State or foreign country)

14. Maiden name Louise Valley

15. Birthplace Washington Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas W. Boyer

(b) Address Cadet, Mo. R.I.

17. (a) Burial (b) Date thereof 4-20-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blackwell, Mo.

18. (a) Signature of funeral director Thos Wm Boyer

(b) Address Blackwell, Mo.

19. (a) 4-20-1944 (b) Joseph L. Thurman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1944 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from April 13, 1944, to April 19, 1944
that I last saw him alive on April 13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death premature under developed - unable to take nourishment

Duration
1

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature Joseph L. Thurman (M. D. or other).....

Address Patton, Mo Date signed 4-20-1944

RECEIVED

District Health Officer No. 4

District File Number 544-382

Date Filed 5-11-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.